

Michigan Department of Community Health  
**EMS AND TRAUMA SYSTEMS SECTION**  
P.O. Box 30437  
Lansing, Michigan 48909  
(517) 241-0179  
**Website: [www.michigan.gov/ems](http://www.michigan.gov/ems)**

*Authority: P.A. 368 of 1978, as amended  
This form is for information only.*

## **INSTRUCTOR COORDINATOR RE-LICENSURE INSTRUCTIONS**

**To qualify for re-licensure your previous Michigan EMS license must have expired within the last three years. All other applicants must use the initial Application for Licensure form.**

### **INSTRUCTOR/COORDINATOR RE-LICENSURE**

1. Complete the re-licensure application form marking the box for Instructor Coordinator and submit it with the appropriate fee to the EMS & Trauma Systems Section with the check or money order made out to the State of Michigan. **Application fees are non-refundable.**
2. If you have a yes answer to question number 1 on the application, you must complete the attached criminal conviction history form DCH-HLD-002 (8/11).
3. If you have a yes answer to question 2 on the application, you must submit a detailed explanation with your application.
4. With your application submit copies of certificates or other acceptable documentation of Instructor Coordinator continuing education credits. Refer to Instructor Coordinator Continuing Education Record Form BHPPA/EMS-128 available at the website. **All CE's must have been completed within three years of the date of the re-licensure application.**
5. Complete Part I of the Verification of Field Experience Form. Forward it to the agency representative for completion of Part II verifying your **FIELD experience** as an MFR, EMT, EMT-Specialist, or Paramedic. Completion of this form verifies that you have completed the field experience, for a minimum of three years at or above the level you are applying for, providing direct patient care with a licensed Life Support Agency. **If you have worked for more than one agency during the three-year period you may copy this form and submit it to more than one agency director.**
6. Failure to complete the application in its entirety and correctly may result in a delay of the processing of your application. This is a two-page application. Be sure to complete both pages/sides, sign and date your application before submitting with the appropriate fee.

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**APPLICATION FOR INSTRUCTOR COORDINATOR  
 RELICENSURE - LICENSE EXPIRED WITHIN LAST 3 YEARS**

Authority: Public Act 368 of 1978, as amended.  
 If this form is not complete a license will not be issued.

**Type or Print Only**

**I AM APPLYING FOR: (Check ONE only)**

- ☐ **Medical First Responder Instructor Coordinator – Fee: \$75.00 71-3205-53**
- ☐ **Emergency Medical Technician Instructor Coordinator – Fee: \$75.00 71-3205-53**
- ☐ **EMT-Specialist Instructor Coordinator – Fee \$75.00 71-3205-53**
- ☐ **Paramedic Instructor Coordinator – Fee: \$75.00 71-3205-53**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH. Fees are deposited upon receipt and are NON-REFUNDABLE.**

**State Office Use Only**

License Number

Date of Licensure

First Name	Middle Name	Last Name
U.S. Social Security Number		Date of Birth
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (If Applicable)		Daytime Phone Number

**Check the appropriate answer to each of the following questions.**

1. Have you been convicted of a misdemeanor or felony, other than minor traffic violations? <b>NOTE: Attach criminal conviction history form DCH-HLD-002 (8/11) for a Yes answer</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined, been denied a license or currently have disciplinary action pending against you? <b>NOTE: Attach a detailed explanation for a Yes answer</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name	Social Security Number
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**CERTIFICATION**

**I certify that I am the person named on this application and that all statements are true. Once licensed, I will comply with all applicable state laws and rules.**

**I understand that it is the policy of this agency to secure criminal conviction history as part of the pre-licensure screening process, and I authorize the agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record keeping organization.**

**I further consent to the release of information to this agency regarding any discipline investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state of the United States, military branch of the federal government or any sovereign nation.**

**The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation may be punishable by law.**

Signature	Date
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### VERIFICATION OF THREE YEARS OF FIELD EXPERIENCE FOR INSTRUCTOR COORDINATOR APPLICANTS

To qualify for an Instructor Coordinator license, an applicant must have completed an I/C education course, be currently licensed as an MFR, EMT, EMT-Specialist or Paramedic and have three years field experience at the level applying for.

**Part I: To be completed by the applicant and forwarded to the Licensed Life Support Agency Director for completion.**

First Name	Middle Name	Last Name
Street Address		
City	State	ZIP Code
Current Michigan EMS License Number (Must be currently licensed in Michigan at another level)		Date Issued
U. S. Social Security Number	Date of Birth	Daytime Phone Number

**Part II: To be completed by the Licensed Life Support Agency Director where the applicant obtained their field experience.**

Name of Agency	Agency License Number
Street Address	Telephone Number
City	State ZIP Code
<p>The above named applicant has completed <b>FIELD experience</b> at the level of MFR, EMT, EMT-Specialist, or Paramedic, <b>providing direct patient care with a licensed Life Support Agency</b>. Please indicate level and time this applicant has met this requirement with your agency. (<b>Note: this does not mean their level of licensure</b>)</p> <p>This is to certify that _____ has worked meeting all of the above requirements as an:</p> <p style="text-align: center;">Applicant's Name</p> <p><input type="checkbox"/> Medical First Responder _____ to _____</p> <p><input type="checkbox"/> Emergency Medical Technician _____ to _____</p> <p><input type="checkbox"/> Emergency Medical Technician-Specialist _____ to _____</p> <p><input type="checkbox"/> Paramedic _____ to _____</p> <p style="text-align: center;">(mm/dd/yy) (mm/dd/yy)</p> <p>_____ Signature of Agency Director</p> <p style="text-align: right;">_____ Date of Signature</p> <p>_____ Print or Type Agency Director Name</p>	

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency

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## CRIMINAL CONVICTION HISTORY FORM

Authority: Public Act 368 of 1978, as amended

The Department has received information which indicates you have been convicted of a misdemeanor or felony. Additional information is necessary to process your application. Please complete this form and mail it to the address above or fax it to: (517) 241-9458. Processing of your application is being delayed until this information is received.

First Name	Middle Name	Last Name
U.S. Social Security Number	Drivers License Number	Type of license you are applying for

Conviction #1 Information
Briefly state the nature of the conviction
Date of Violation
Date of Conviction
County, State, & Court of Jurisdiction
Sentence
Please check, if applicable and give date: <input type="checkbox"/> Expunged on: ____/____/____ <input type="checkbox"/> Annulled on: ____/____/____

Conviction #2 Information
Briefly state the nature of the conviction
Date of Violation
Date of Conviction
County, State, & Court of Jurisdiction
Sentence
Please check, if applicable and give date: <input type="checkbox"/> Expunged on: ____/____/____ <input type="checkbox"/> Annulled on: ____/____/____

**NOTE: The back of this form may be used if you have more than two convictions**

### CERTIFICATION

I hereby certify that the above facts and any attached statements are true, accurate, and complete about any and all convictions, and further make application for licensure in Michigan.

Signature of Applicant/Licensee	Date
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The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.